NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

PARTNER: _____ **PARTNER'S PHONE:** (_____) _____-_____

VACCINES

The following vaccines are strongly recommended in pregnancy for the health and safety of you and your baby. They are considered safe in pregnancy and they give your infant immunity until they can receive the vaccine themselves.

Do you refuse the TdaP vaccine (after 27 weeks)? ↑ No ↑ Yes

Do you refuse the flu vaccine (during flu season)? ↑ No ↑ Yes

MEDICAL HISTORY (Check all boxes that apply)

Illness	Yes	No	Illness	Yes	No
Diabetes			D (Rh) Sensitized		
Hypertension (high blood pressure)			Pulmonary (Tuberculosis/Asthma)		
Heart Disease			Seasonal Allergies		
Autoimmune Disorder			Drug/Latex Allergy		
Kidney Disease/UTI			Breast Condition		
Neurologic Disorder/Epilepsy			Gynecological Surgery		
Psychiatric Condition			Operations/Hospitalizations		
Depression/Postpartum			Year/Reason:		
Hepatitis/Liver Disease			Anesthetic Complications		
Varicosities/Phlebitis			History of abnormal pap smear		
Thyroid Condition/dysfunction			Uterine Abnormalities/DES		
Trauma/Violence			Infertility		
History of blood transfusions			ART Treatment		
Hematologic Disorders			Pregnancy Complications		
Gastrointestinal Disorders			Cancer/What type:		
Dermatologic Disorders			Relevant Family History		
			Other:		

Any medications, tobacco, alcohol, illicit or recreational drugs (legal or otherwise) since last period?

↑ No ↑ Yes. List: _____

GENETIC SCREENING

Include yourself, baby's father, or anyone in either family with the following:

Illness	Yes	No	Illness	Yes	No
Your age is 35 years or older as of due date			Huntington's Chorea		
			Mental Retardation		
Thalassemia			Autism		
Neural Tube Defect			Other genetic/chromosomal Disorder		
Down Syndrome			Maternal Metabolic Disorder (Diabetes)		
Tay-Sachs Disease					
Canavan Disease			Patient or baby's father had a child with a birth defect not listed above		
Familial Dysautonomia					
Sickle Cell Anemia			Cystic Fibrosis		
Hemophilia			Recurrent pregnancy loss or still birth		
Muscular Dystrophy			Child with birth defects		
Medications (including supplements, vitamins, herbs, or OTC drugs) since last menstrual period:					
Other:					

INFECTION HISTORY

Illness	Yes	No	Illness	Yes	No
Live with or exposed to someone with tuberculosis			Chlamydia		
You or partner has history of genital herpes			HPV		
Rash or viral illness since last menstrual period			HIV		
Prior GBS infected child			Syphilis		
Hepatitis B or C			Other sexually transmitted infection. Please indicate:		
Gonorrhea			Other:		

Name _____

MRN _____

St. Joseph Health Medical Group

OB/GYN SUPPLEMENTAL HEALTH QUESTIONNAIRE